**Klement Family Dental Care**
7650 38th Avenue North
St. Petersburg, FL 33710

(727) 343-8831 phone
(727) 345-5396 fax
www.StPeteDentist.com

# Patient History (Child)

Date: ____-____-___

Legal Name: _____ Sex: ☐M ☐F
Last Name First Name Middle Initial

Preferred Name: _____ DOB: ____-____-_____ Social Security #:_____-_____-_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone: ( ) _____-_____ Work Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____

Email: _____ Preferred Contact #:(please circle) Home Work Cell Email

How did you hear about our office? _____

Do Both Parents Live Together? _____ If not, with whom does the child reside?_____

Mother's Name: _____ Cell/Alternate Number: ( ) _____-_____

DOB: ____-____-_____ Social Security #:_____-_____-_____ Work Phone: ( ) _____-_____

Father's Name: _____ Cell/Alternate Number: ( ) _____-_____

DOB: ____-____-_____ Social Security #:_____-_____-_____ Work Phone: ( ) _____-_____

Does your child have dental insurance? _____ Primary Insured: _____

Is there a secondary dental insurance plan? _____ Primary Insured:_____

**Please present your insurance card to our front staff to verify coverage and benefits.**

# Dental History (Child)

Is this your child's first visit to the dentist? _____NO _____YES

Has your child had problems with past dental treatment? _____NO _____YES

If YES, please explain: _____

How often are your child's teeth brushed? _____ By Whom? _____Self _____Parent

Does your child suck his/her thumb, finger, lip, etc? _____NO _____YES

Does your child have a dental condition about which you are concerned? _____

# Medical History (Child)

How would you rate your child's health? Excellent Good Fair Poor

Is your child currently under the care of a physician other than for routine care? _____NO _____YES

If yes, please explain: _____

Has your child been hospitalized in the past year? _____NO _____YES

If yes, please explain: _____

Name of your child's physician: _____ Phone: ( ) _____-_____

Address: _____Date of last complete exam? _____-_____-___

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*** Is your child allergic to or have adversely reacted to any of the following?** No_____ Yes_____

*** If YES, please check the appropriate substance:**

__Aspirin __ Tylenol __ Codeine __ Local Anesthetic __ Latex

| | | | |
|---|---|---|---|
| __ Erythromycin | __ Tetracycline | __ Penicillin | __Keflex |
| __ Clindomycin | __ Doxycycline | __ Amoxicillin | __ Ceclor |
| __ Z-Pack(Zithromycin) | __ Minocycline | __ Augmentin | __ Cephalexin |
| __ Biaxin(Clarithromycin) | | __ Ampicillin | |

*** Are you aware of your child being allergic to any other medication or substance?** No _____ Yes_____

* If YES, please explain: _____

*** Please list any medications your child is currently taking:**

1._____ 2._____ 3._____ 4._____

*** Please check any of the following that your child has had or have at present:**

| | | |
|---|---|---|
| _____Artificial Joints (hip, knee, etc.) | _____Mental Retardation | _____Hepatitis C |
| _____Mitral Valve Prolapse | _____Stroke | _____Speech Problems |
| _____Artificial Heart Valve | _____Asthma | _____Liver Disease |
| _____Rheumatic or Scarlet Fever | _____Alzheimer's | _____Hemophilia |
| _____Synthetic Vascular Heart Graft | _____High Blood Pressure | _____Blood Transfusion |
| _____Infectious Endocarditis | _____Thyroid Disease | _____Drug Addiction |
| _____Hemodialysis Patients w/ | _____Kidney Trouble | _____Arthritis |
| _____Fistula or Shunt | _____Radiation Treatment | _____Diabetes |
| _____Neuro-surgical Shunts | _____Chemotherapy | _____Bruise Easily |
| _____Portocaval Shunts | _____Tuberculosis | _____Epilepsy or Seizures |
| _____ Heart Murmur (Organic) | _____HIV Positive | _____Psychiatric Treatment |
| _____Heart Murmur (Func./Innocent) | _____AIDS | _____Fainting or Dizziness |
| _____Heart Failure or Disease | _____ARC | _____Sinus Trouble |
| _____Heart Pacemaker | _____Venereal Disease | _____Fever Blisters |
| _____Congenital Heart Lesion | _____Hepatitis A | _____Yellow Jaundice |
| _____Heart Surgery | _____Hepatitis B | _____Hyperactivity |

IS YOUR CHILD SUBJECT TO PROLONGED BLEEDING? No_____ Yes_____

***FOR WOMEN ONLY:*** Are you taking birth control pills? No_____ Yes_____

Are you pregnant? No_____ Yes_____

_____

***PATIENT'S SIGNATURE***

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| INIT | | | | | | | | | | |
| DATE | | | | | | | | | | |